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JONES ON FUNCTIONAL NERVOUS DISORDERS,

16 PAGES.

### CLINICS.

#### CLINICAL LECTURES.

Two Lectures on the Laryngoscope. Delivered at the Royal College of Physicians by GEORGE JOHNSON, M. D., Prof. of Medicine in King's College, &c. &c.

#### LECTURE II.

The larynx, being the door keeper of the lungs, as well as the organ of the voice, is largely supplied with nerves and endowed with exquisite sensibility. Its muscular apparatus is therefore readily thrown into a state of spasm, not only by direct irritation of the larynx itself, but by disturbing influences transmitted from a distance through the nerves. That distressing disease, laryngiamus stridulus, or crowing inspiration, in children, affords a good illustration of a purely spasmodic affection of the larynx, yet one which is often fatal. Even in cases of organic disease of the larynx, and in adults, there is very commonly a tendency to spasm,

and before the introduction of the laryngoscope it was often impossible to determine to what extent the symptoms were the result of structural change within the larynx, and how far they were due to spasm of the laryngeal muscles. Now, by the aid of the mirror, this difficulty has been in a great degree removed.

Many years ago (in February, 1847) I was asked by a friend to examine the body of a man who had died, at the age of twenty-nine, of what was believed by two gentlemen who attended him to have been acute laryngitis. The symptoms had been, cough, hoarseness, dyspnoea with stridor, a hot skin, and a quick pulse. The dyspnoea was increased from time to time in paroxysms; at length one of these paroxysms resulted in suffocation. The larynx was found quite healthy, but in the chest there was a large cancerous tumour which filled up the arch of the aorta and involved the branches of the pneumogastric nerve. The laryngeal symptoms had been purely

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spasmodic—a result of irritation of the nerves by the cancerous tumour in the chest.

The laryngoscope was not then in use. Now that we have that instrument, an error of diagnosis in such a case could result only from negligence.

In July last year a man, thirty-one years of age, was admitted into the hospital under my care with symptoms which were at first supposed to indicate laryngitis. He had a cough with dyspnoea, loud laryngeal stridor and hoarseness. On examination of the larynx by the mirror with sunlight, I found only very slight congestion of the mucous membrane, and I at once declared that the laryngeal symptoms were the result of spasm and not of inflammation or other structural disease within the larynx. Aneurism of the aorta was then suspected and carefully sought for, but no physical sign of aneurism could be found. There was no abnormal dulness on percussion, no pulsation, no morbid sound, no inequality of the pupils or of the pulse at the wrists. One suspicious symptom, however, was a difficulty in swallowing solids, which had come on about eight days before his admission. It was likely, therefore, that a tumour—probably an aneurism—was pressing on the oesophagus and on the recurrent nerve. Four days after his admission he died from the bursting of an aneurism into his oesophagus. Some blood was ejected from the mouth, but the greater part passed into the stomach. An aneurism about the size of a small orange was found at the back of the transverse portion of the arch of the aorta : it had pressed on the oesophagus and opened into it. The stomach was full of blood. The left pneumogastric nerve passed in front of the aneurism, and was somewhat flattened ; the recurrent branch passed behind the tumour, and had evidently been stretched and compressed by the aneurism.

In this case the laryngoscope was of considerable use. It clearly showed the absence of laryngitis, and thus rendered it probable that an aneurism was the cause of the laryngeal symptoms. The patient therefore was spared the ordinary treatment for laryngitis. Nauseating doses of antimony or ipecacuanha would probably have excited vomiting, and might have hastened the rupture of the aneurism.

Pressure on the nerves within the chest may paralyse them, or rather the muscles

which they supply, and cause *aphonia* without laryngeal spasm.

In March, 1863, a man was under my care in the hospital with extensive cancerous disease within the chest. The whole of the left lung was solid, and impervious to air; the superficial veins over the chest and on the head and neck were much enlarged. He had a mass of cancerous glands above the right clavicle. He spoke only in a faint whisper; but there was no sign of obstruction in the larynx, neither stridor nor dyspnoea. The larynx showed the tips of the arytenoid cartilages resting against each other, and quite motionless. The glottis was always open to the extent of about one-eighth of an inch ; it neither opened wider during inspiration, nor closed when he attempted to vocalize. This immobility of the glottis was, without doubt, a result of paralysis of the laryngeal muscles consequent on pressure upon the nerves by the cancerous mass within the chest. The poor man determined to leave the hospital before his death, so that we had no post-mortem examination; but the nature of the disease was very evident.

In most cases of inflammation of the larynx there is more or less of spasm; but the tendency to spasm varies much in different cases, depending probably upon the varying degrees of susceptibility of the nervous system in different individuals. Two cases of laryngitis which have recently been under my care in the hospital afforded a striking contrast with regard to the excitability of the larynx. Both patients were women. One was thirty-two years of age, of very nervous, excitable temperament. She had cough, hoarseness, dyspnoea, and loud laryngeal stridor. On examination with the laryngoscope, the mucous membrane of the larynx was seen to be congested and swollen; but it was evident that the stridor during inspiration and much of the apparent distress were the result of spasm. She closed the glottis during inspiration, and the air was drawn through it with a loud noise; but that there was no mechanical impediment to the opening of the glottis was clear, from the fact that immediately after inspiration was over the glottis opened to its full extent. There was a perverted muscular action which closed the glottis during inspiration, and opened it during expiration. In this case the symptoms were greatly relieved

by the internal use of morphia and chlorodyne, and by the local application of a solution of morphia in glycerine to the larynx by means of a brush.

In marked contrast with this case was that of a woman, aged twenty, who complained of some pain in the throat, dyspnoea, difficulty in swallowing, and hoarseness; yet, withal, as my clinical clerk, Mr. Shuttleworth, noted, there was "marked absence of restlessness and anxiety, her countenance wearing an expression of profound indifference." The manners and the physiognomy of the patient were such as to excite a suspicion that the throat symptoms were simply nervous and hysterical; yet, on examination with the mirror, I found the epiglottis much congested, the false cords red and swollen, and over the left arytenoid cartilage a red inflammatory swelling of the mucous membrane as large as a marble. The swelling soon subsided under the use of antiphlogistic remedies, and she left the hospital well.

Without the aid of the laryngoscope in these two cases, we should have formed a very incorrect opinion as to the state of the larynx. In the first case we should have over-estimated, in the second we should have under-estimated, the amount of structural change. In each case, too, a correct diagnosis suggested a more appropriate treatment than would otherwise have been applied.

In some cases of *syphilitic laryngitis*, which have come under my observation during the last two years, laryngoscopic examination has afforded some very interesting results.

A woman, aged forty-one, was admitted under my care on June 8th, 1863. There was a history of primary syphilis two years before, and this was followed by sore-throat, bronchitis, and eruption on the skin. For six months before her admission there had been hoarseness and occasional dyspnoea.

At the time of admission the dyspnoea was very urgent, inspiration being prolonged and heaving, and attended with loud laryngeal stridor. The voice was very thick and husky; the skin and lips of a dusky hue.

Examination by the laryngoscope, which was well borne, showed considerable thickening of the mucous membrane over the arytenoid cartilages and at the side of the larynx—that is, in the situation of the false cords. No ulceration was apparent.

The glottis was much narrowed, so that she breathed through a small triangular opening at the back part of the glottis. The epiglottis was slightly injected, but not thickened. There were patches of syphilitic pectoriasis on various parts of the body. Three leeches were applied outside the larynx. She was directed to inhale steam, and to take five-grain doses of iodide of potassium three times a day. During the twenty-four hours after her admission the dyspnoea became more urgent and alarming.

Now the advantage of the laryngoscope in the case was this; it showed such an amount of swelling and obstruction in the larynx as the most successful medicinal treatment could not be expected to remove within a period of several days, while the narrowing of the glottis was so great as to threaten speedy suffocation. We were therefore emboldened to resort to tracheotomy before the lungs had become gorged to such an extent as to render the operation useless. Accordingly tracheotomy was performed by Mr. Antonini (the house-surgeon) the day after admission; the relief was great and immediate. She then took corrosive sublimate and iodide of potassium until the gums were slightly affected. Meanwhile we were enabled to watch the gradual diminution of the swelling within the larynx, and the gradual opening of the glottis, until at length it expanded to its full extent.

The tube was removed on the 15th of July, and she left the hospital on the 1st of August. There was then only a slight huskiness of the voice, the only morbid appearance in the larynx being a slight roughness and a dull red colour of the true cords.

Quite recently, a case of syphilitic disease of the throat has been associated with a remarkable alteration in the form of the epiglottis. A woman aged twenty-five was admitted on the 11th of March with syphilitic ulcers on the soft palate and on the back of the pharynx. There was some thickness of the voice and difficulty of swallowing, and there had been occasional dyspnoea. On examination with the laryngoscope, I saw that there was an ulcer on each side in the glosso-epiglottidean fold, just beyond the margin of the epiglottis. The epiglottis itself was red and thickened, and so much folded downwards that the two sides of its laryngeal surface were

nearly in contact, and it was impossible to see into the larynx. This remarkable doubling up of the epiglottis was evidently a result of inflammatory swelling, extending from the ulcer at its margin over the lingual surface of the epiglottis. I have seen the reverse of this in some cases of tubercular ulceration commencing within the larynx. The mucous membrane on the laryngeal surface of the epiglottis has become thickened and swollen, and the result has been that the epiglottis has been flattened out, and has lost its usual arched form.

To return to our case of folded epiglottis. The woman was ordered to have a calomel vapour bath every night, and one-sixteenth of a grain of corrosive sublimate with five grains of iodide of potassium three times a day. In ten days the gums became slightly sore; the ulcers all rapidly healed; and as the thickening of the epiglottis diminished it became unfolded, opened out, and returned to its normal form. We could then see under it into the larynx, which was healthy.

I watched this case with much interest, and with some anxiety, for two years ago I had under my care a similar case, which ended fatally in a very sudden and unexpected manner. A man was admitted on the 15th of May, 1862, with an ulcer on each tonsil and a syphilitic eruption on the skin. There was some stridor with inspiration, but no dyspnoea, except after swallowing food, when he had occasional attacks, during which he was nearly suffocated.

At that time we had not learned to use the laryngoscope, and we were therefore in the dark as to the condition of the epiglottis and larynx; but the house-surgeon was requested to hold himself in readiness to perform tracheotomy if necessary. On the evening of the third day after his admission he was again seized with a fit of suffocation after swallowing food. The house-surgeon was sent for, who opened the trachea; but it was too late—the man was dead. We found that the syphilitic ulceration had extended from the tonsils to the edge of the epiglottis, and the epiglottis itself was thickened and doubled up exactly as in the case which I have just now related.

The probable explanation of the attacks of dyspnoea after swallowing appears to be this: During deglutition the opposed surfaces of the folded epiglottis were pressed together by the action of the pharyngeal

muscles; the elasticity of the epiglottis being impaired by the inflammatory swelling on its outer surface, the opposed surfaces would not immediately separate when the act of deglutition was over, and then probably the pressure of the atmosphere during a forcible effort at inspiration would tend to keep the surfaces together and prevent the opening of the fold. Thus the folded epiglottis would act as a valve, and prevent the entrance of the air. Another explanation which suggests itself is that, in consequence of the irregular swelling of the epiglottis, the food entered the larynx during the process of deglutition, and excited suffocative spasm. Whatever may be the immediate cause of the distressing symptoms, it is evident that causes of this kind require very careful watching. And if we find, on laryngoscopic examination, that the epiglottis has assumed this folded appearance, the occurrence of one or more attacks of urgent dyspnoea after swallowing food would call for the immediate performance of tracheotomy, in order to prevent sudden death from suffocation before our remedies have had time to act on the disease.

On the 21st of July, 1863, I first saw, with my colleague Mr. Mason, a gentleman twenty-two years of age, who for about a year had been suffering from secondary syphilis. His face was much scarred by ulcers, which had all healed. At the time of my visit he complained of great pain and difficulty in swallowing, and the voice was husky. On examination with the laryngoscope, I saw an ulcer in the inter-arytenoid fold, in the boundary wall between the larynx and the pharynx, and just in the position to be irritated by the passage of food. He was treated by calomel vapour baths, with iodide of potassium and bark internally; and the ulcer was occasionally touched with a solution of nitrate of silver by means of a brush on a curved whalebone handle. The ulcer healed, the patient gained flesh and strength, and for a time the cure appeared to be complete. In the autumn, however, he returned to me, complaining of dyspnoea on exertion, a loud ringing cough, and stridor during a deep inspiration. Now, on examination of the larynx, we found that the cicatrix of the ulcer had contracted, and drawn together the arytenoid cartilages, so that the vocal cords are scarcely more than one-tenth of

on inch apart; and through this narrow fissure he breathes. That is his condition at the present time. I have asked several of my laryngoscopic friends to examine this gentleman. We all agree as to the condition of the larynx. I have had it in my mind to cut the cicatrix, so as to set free the cartilages; but fearing that the same contraction would follow the healing of the incision, I have done nothing but watch the symptoms. A distinguished surgeon, who saw the patient and heard the stridulous breathing, but who did not look into his larynx, suggested that he should take more mercury for the removal of the obstruction in the throat; but it is certain that mercury could have no more influence upon this scar in the larynx than it would have upon the scars which have disfigured his face.

A man about forty-five years of age was admitted under the care of my colleague, Dr. Beale, on the 12th of December, 1863. His habits had been very intemperate. He said that five days before his admission he had been seized with sore-throat, hoarseness, and difficulty of breathing. At the time of admission these symptoms were still present, and inspiration was attended with loud stridor. He was so feeble that it was difficult for him to sit up in bed while I examined him with the laryngoscope. I found the mucous membrane of the larynx somewhat congested, but not swollen; but I saw clearly that the vocal cords were nearly in contact and motionless. This position of the cords accounted for the dyspnoea and stridor. But why were the cords thus in contact? I thought that possibly inflammation might have involved the crico-arytenoid articulation, and so rendered the cartilages immovable by a kind of ankylosis.

Tracheotomy was performed by Mr. Wood, but the man sank, and after death it was found that the arytenoid cartilages had become necrosed, and apparently had escaped each through an ulcerated opening in the mucous membrane; a small calcareous fragment only of each cartilage remained. This destruction of the cartilages accounted for the collapse of the glottis and the immobility of the cords.

I have seen two patients in whom difficulty of swallowing was a chief symptom, and who on that account were supposed to have stricture of the oesophagus, until the

laryngoscope revealed the true nature of the disease.

One was a man sixty-four years of age, who came under my care at the hospital in March, 1863. He had experienced difficulty in swallowing solids for about seven months, and of late there had been difficulty in swallowing liquids. There was neither dyspnoea nor hoarseness, but his voice had somewhat of a nasal sound. On examination by the laryngoscope, the epiglottis was seen greatly deformed and thickened; its surface, moreover, granular, and here and there ulcerated; it was so large as nearly to fill up the pharynx, and thus the difficulty in swallowing solids was fully explained. When the tongue was much depressed the epiglottis could be partly seen without the aid of the mirror. Examined by the finger, it had a hard and inelastic feel. Without doubt the disease is of the nature of epithelial cancer. On one occasion a piece the size of a horse-bean became detached and was expectorated: its microscopic characters were those of epithelial cancer. I have seen this man from time to time up to within the last few days. The disease has made very little progress, the lymphatic glands are unaffected, and his general health has suffered little impairment.

The other case of dysphagia was that of a farmer, seventy-five years of age, who was sent to me by Mr. Roberts, of Dunster, in Somersetshire, in December, 1863. He had complained of cough, with rather copious expectoration, and great difficulty in swallowing, for about ten weeks. The voice was somewhat husky. On examination I found edematous swelling of the mucous membrane of the larynx, the swelling being most prominent over the arytenoid cartilages. This swelling evidently prevented complete closure of the larynx in deglutition, and caused the dysphagia. Mr. Erichsen afterwards saw this patient, passed an oesophageal bougie, and declared that there was no stricture. The swelling was rapidly reduced, and the difficulty of swallowing relieved by scarification over the most prominent part of the tumour, followed by the application of solution of nitrate of silver on a brush.—*Lancet*, July 23d, 1864.

(To be concluded in our next No.)

## HOSPITAL NOTES AND GLEANINGS.

*Clinical Remarks on Lithotomy and Lithotripsy.*—By HOLMES COOTZ, Esq., F. R. C. S., Surgeon to St. Bartholomew's Hospital. Although, gentlemen, you cannot attach more than a guarded amount of importance to surgical statistics, yet it may interest you to know that during the past two years the lateral operation of lithotomy has been performed thirteen times in St. Bartholomew's Hospital, with a mortality of two, amounting to a death-rate of 13.33 per cent. But this does not include the case of a man, aged twenty-five, in whom a calculous deposit formed around a canula introduced into the bladder after puncture above the pubes for retention of urine. Mr. Callender, who had charge of the case, very properly dilated the fistulous passage, extracted the "stone" without cutting, and the patient recovered. On the other hand, four patients have been subjected to the operation of lithotomy, and of these two have died, making a death-rate of 50 per cent.

Let us next inquire into the causes of death in these two groups of cases. After the operation of lithotomy, of the two fatal cases, one, aged four years, died from diarrhoea; the other, aged sixty-three, from acute inflammation of a thickened bladder.

After the operation of lithotomy, of the two fatal cases, one, aged fifty-three years, died from bronchitis and abscess of the kidneys; the other, aged forty-seven years, from acute inflammation of the bladder, and granular degeneration of the kidneys.

These facts have been furnished me by the surgical registrar, Mr. Willett, whose accuracy and intelligence we all respect.

I grant that the data here given are not sufficiently large for permanent deductions; and yet they correspond with the general impression formed respecting the relative merit of the two operations—namely, that the dangers attending lithotomy are greater than are commonly supposed, and that the very favourable returns quoted by some surgeons proceed from their considering each "sitting" as a completed case; whereas the result should be regarded only after the patient has been freed of his complaint. The late Mr. Stanley was well aware of the dangers attending lithotomy; indeed he delivered a clinical lecture in this theatre in illustration of the fact. I believe that I

express his opinion in saying that the operation of lithotomy is suited almost exclusively to cases of men in middle or advanced life, of gouty habit, and with a deep perineum, in whom, after intervals of a few months, a small uric acid calculus drops from the kidney into the bladder, the kidneys being in their general structure healthy. In such cases you may give the patient much relief and greatly prolong his life by crushing each uric acid calculus soon after it has dropped into the bladder, and while it is yet small.

The lithotrite also is useful in breaking up concretions formed around foreign bodies introduced into the bladder. From Ser. 36 (No. 196) I have selected this specimen. It consists of parts of a gutta-percha bougie, about five inches in length, incrusted with deposits of lithate of ammonia, ejected from a man's bladder after being broken into several pieces by lithotomy. The bougie was being passed by the patient twenty-seven days prior to its removal, when it broke between four and five inches from its distal extremity, the fragment being left in the bladder. A surgeon immediately attempted its removal by cutting into the urethra through the perineum, but a spasmodic action of the membranous portion ensued, and the whole fragment was drawn into the bladder. It there lay across the neck, was readily reached with the lithotrite, turned, and an effort made to withdraw it; subsequently I broke it into several pieces, each, as you see, about an inch in length. They were expelled at one act of micturition violently from the bladder the day following the last operation.

In this specimen (Ser. 36, No. 194) you see a portion of sealing-wax, which had been introduced into the bladder three years prior to its extraction. It is almost entirely incrusted with calculous matter.

The lithotrite should under no circumstances be used for the purpose of crushing an oxalate of lime calculus, the character of which is generally recognized by its sharp, ringing sound. The fragments are always sharp and irritating to the bladder, and it not uncommonly happens that the lithotrite fails to act on the great mass of the stone.

Most calculi are composed of uric acid. We have a collection of above 200, and of these there are of uric acid alone, 30; of urate of ammonia, 13; of calculi composed

of two layers, uric acid nucleus, 16; urate of ammonia nucleus, 25; of calculi composed of three layers, uric acid nucleus, 7; urate of ammonia, 18; total, 111. But this number would be much higher were it not that very many uric acid and urate of ammonia calculi have been thrown away as too small and too common for preservation.

Next in frequency comes the oxalate of lime calculus, amounting to 40; of the fusible calculus, 19; phosphate of lime, 11; cystic oxide, 2. The other specimens are composed of carbonate of lime, or are concretions formed upon foreign bodies.—*Lancet*, Dec. 31, 1864.

*Cases of Chorea with Clinical Remarks.*—Chorea shows well the danger there is in thinking of a disease as one of a nosological division. Although in one sense a disease of the nervous system, its frequent association with rheumatism shows that it would be a great error to work at it as a nervous affection only. What its precise association with rheumatism may be is a question very much disputed. Some think that the rheumatic "poison," be it what it may, produces chorea by its direct effect on the nervous centres; others, as the late Dr. Kirkes, that the association is indirect—with organic disease of the valves of the heart. There is certainly very frequently a murmur in chorea, but as to the interpretation of this murmur there are various and contradictory opinions. Dr. Walsh thinks it is frequently due to irregular action of the muscular apparatus of the valves. Other physicians think that it is frequently due to organic disease of the valves themselves. According to the late Dr. Kirkes, vegetations are invariably found on the valves at post-mortem examinations of patients who have died of chorea. We have frequently heard Dr. Wilks and Dr. Andrew make the same remark. But admitting that the connection is, as Dr. Kirkes believed, between valvular disease and chorea, and not directly between rheumatism and chorea, we have difficulties in explaining the manner of the connection. The association of some other diseases of the nervous system—hemiplegia, for instance—with valvular diseases is, as Dr. Kirkes first pointed out, by embolism. It is possible that a similar explanation may hold good as regards chorea. Yet chorea, even when strictly unilateral, cannot be due

to plugging of any main trunk, like the middle cerebral, or there would be actual paralysis. Dr. Kirkes believed that the direct causes of the motor phenomena of chorea were partly the circulation of morbid blood in the brain, and partly the temporary obstruction of the minute capillaries by fibrinous particles. Dr. Hughlings Jackson has suggested that the cause may be obliteration of the small branches supplying convolutions near the corpus striatum. It seems certain that there are convolutions in this region which have to do with guiding the muscles of articulation; and it may be reasonably supposed that there are others for corresponding actions of the muscles of the limbs.

The following cases of chorea, with remarks, by Dr. Russell, are valuable additions to the clinical history of chorea. It is most important to complete the clinical history of this disease, as it has a wide bearing on the pathology of the nervous system:—

The first case is of interest by showing in a typical manner the presence of two factors, both of which are frequently in combined operation in producing the disease, viz., a depressed (paretic) condition of the nervous centres and remote irritation in the shape of valvular or other disease of the heart. This union of causes was especially insisted upon by Dr. Kirkes (*Medical Times and Gazette*, June 20, 1863) as very influential in producing chorea.

In this patient the cardiac affection, which was undoubtedly in part, if not wholly, connected with the preceding rheumatic fever, was closely connected with the outbreak of the chorea. On the other hand, the occupation of the patient, the protracted exposure to muscular effort day by day in a young and growing boy, and the obvious evidence of fatigue which his history affords, conjoined with his attenuated frame, afforded ample testimony to the existence of great exhaustion of cerebral and spinal power. To such exhaustion the highly emotional character of the boy fully answered, and probably his sudden death must be in great part attributed to the same cause. In the post-mortem examination, although the pale softening of the nervous centres—noticed by Dr. Kirkes as observed in all the fatal cases of chorea examined by himself, and in a large number of those recorded by others—was not present; yet the emaciated

condition of the brain, as shown by its separated convolutions and by the increase in the subarachnoid fluid, and also the empty state of the minute arteries of the brain and cord, fully answer to the same description of disease.

*Chorea—Recent Pericarditis and Endo-carditis—Death by Fainting.*—J. B., aged 14, a messenger of the Electric Telegraph Company. He was sometimes occupied for twelve hours, as a day's work, and suffered much from fatigue. He would come home quite fagged. He had, besides, a poor appetite for meat. He has been very much exposed to wet and cold, not only in his occupation, but also in consequence of very defective accommodation provided for the boys at head-quarters. His father is very rheumatic, and when a boy had chorea.

The patient had his first attack of rheumatic fever, after exposure, in September last. During the fever his side was blistered, and his doctor said that his heart was inflamed. He was confined to bed for a fortnight, and three days after he got up the chorea commenced. The movement at first affected the left side of the body; but whilst in the Hospital each side of the body seemed affected to an equal degree. He was much emaciated, exceedingly emotional, but very quick and intelligent.

The choreic movements at his admission, four days after the commencement of the attack, were very severe and general, implicating the muscles of the face and eyeballs, and at times rendering articulation unintelligible. In the chest the physical signs indicated the disease in the heart discovered after death, though Dr. Russell was not then aware of its full extent.

His amendment after his admission was very rapid, and for the first week was effected without the aid of medicine, the treatment being confined to rest in bed and nutritious diet; subsequently he took zinc, and then steel and cod liver oil.

Unfortunately, he was sent too early to the Convalescent Institution, whence he returned with effusion into his chest and increase of the movements. He was confined to bed; but one evening he got up to go to the water-closet, and in returning fell forwards on his face, and was taken up dead.

*Autopsy Sixty Hours after Death.*—Considerable emaciation; general fluidity of the blood. The large veins of the pia mater were full of blood; a spot of ecchy-

mosis, about the size of a sixpenny piece, existed on the left hemisphere. A considerable quantity of sub-arachnoid fluid lay over the surface of the brain, and the sulci between the cerebral convolutions were much increased in width. The vessels at the base of the brain were perfectly healthy, their branches quite pervious. The gray matter of the convolutions, Dr. Russell thought, was rather pale. Every part of the brain was beautifully healthy in structure; the edges of the sections were sharp, and not a particle of cerebral tissue adhered to the scalpel.

The tissue of the cord was equally firm and healthy. Dr. Russell examined by the microscope the spinal cord and one corpus striatum, and says: "So far as my means of investigation extended, these organs were perfectly healthy, with one exception; that in each there was marked deficiency of blood in the minute vessels; the contrast in this particular between them and the corpus striatum of an old hemiplegic patient which I had examined the night before was most striking."

The heart presented the remains of recent pericarditis, in an universally adherent pericardium. The left ventricle was, besides, greatly dilated, and hypertrophied to a corresponding degree. A thin layer of lymph lay upon the lining of the left auricle, and the mitral valve was thickened and pucker'd at the edge. The pulmonary artery was perfectly free. The other organs were healthy.

A portion of the history of another case of chorea is added by way of contrast to the preceding, as it illustrates the operation of a cause which acted directly and solely upon the brain. Severe mental emotion, in the shape of fright, induced in a child constitutionally feeble, sufficed to bring on the disease almost immediately; the rheumatic and cardiac element being entirely wanting.

*Chorea from Fright—Heart Healthy.*—A. W., aged 7, a feeble child of a family apparently consumptive, but quite free from rheumatic tendency, has never suffered from rheumatism, unless some pain in his joints, which is relieved by rubbing, is to be referred to that disease. Ten months ago the child was taken to see his dead mother; he was impressed by the sight, but not mischievously. Two days after he was locked up in a dark room by a servant

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girl from noon till eight in the evening. His screams at last aroused the neighbours, and he was taken out through the window. Next morning at breakfast, the boy looked ill; he shook in every limb, and was not able to hold his cup. This was the commencement of the chorea, from which he had never fairly recovered. His sleep was disturbed after the fright; he was afraid to go to bed in the dark, and screamed in his sleep. At the same time he lost his appetite, and his spirits were depressed. His memory also became impaired; "he seemed to lose his recollection of his learning," and "he gets very forgetful," and learns with difficulty. In all these particulars he has undergone a complete change.

The choreic movements have been confined to the right side. His articulation has never been affected. He is a very small-made child, with dark hair and eyes, thin, and delicate. Repeated examination fails in discovering any abnormality connected with the heart, save feebleness of impulse according with the general weakness of his body.

It may, however, happen that mental influence and cardiac disease may co-exist in the same subject. Of this the following case is an example. There can, however, be no hesitation in assigning the alarm as the immediate cause of the chorea. The disease of the heart may not improbably date from the attack of scarlet fever in childhood, and doubtless co-operated with the other unfavourable influences noticed in the history to depress the power of the nervous centres.

*Chorea after Fright—Mitral Disease of the Heart.*—A. P., aged 17. Her family history and her own are quite free from rheumatic tendency, but her father was insane. She had scarlet fever when very young, but has never suffered from short breath until quite lately. She has been much confined at a very sedentary occupation, and has lived very badly: she looks dirty and ill cared for. Six months before Dr. Russell saw her she was on the water with a pleasure party, when the boat filled, and she was in danger of drowning.

The alarm effected an entire change in her mental condition; she became extremely nervous and timid; at times she has been hysterical and "awfully passionate." Her nights have been unquiet, she

dreams vividly, and was deeply impressed by her dreams; one night she became persuaded that her sister's child was dead, and was with difficulty persuaded of the groundlessness of her fears. She has even been quite "wild." In all these respects her character has become quite unlike what it was before the accident. Her intellectual faculties, however, have remained entire.

Her aunt cannot fix the exact date of the commencement of the chorea; she never worked after one week from the date of the fright, but it was a month before she had medical attendance: she was then declared to be suffering from St. Vitus's dance. On closer questioning, however, it was ascertained that a week after the fright she was obliged to leave off work because she could neither thread nor use her needle; she drew out the thread as fast as she put it in, or twisted it about.

The left side of the body was chiefly affected, the lips and tongue inclusive, so that articulation was impaired.

On examining her chest, a soft systolic bellows sound was heard at the apex of the heart; no bruit was present in the course of the aorta.

She perfectly recovered in seven weeks under morphia, tonics, and cod-liver oil: her sleep also became sound. It is to be particularly observed that the bellows sound underwent no change after the cessation of the chorea.—*Med. Times and Gaz.*, Jan. 28, 1865.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Attention by the Sanitary Commission to the Comfort of United States Soldiers.*—An officer of the British army, in a communication published in the number of the *Edinburgh Medical Journal* for January of the present year, states: "The sick and wounded soldiers of no other service have been so well cared for in regard to his creature comforts as the Federal. What with the Sanitary, Christian, and State Commissions, acting independently of the Purveying Department, the requirements of the army hospitals have been well supplied. These Commissions act as adjutants to the Medical Department; not professing to control or interfere in any way with the arrangements thereof, but only

assisting in ameliorating the distress of the sick and wounded. The Sanitary Commission, from its influential connections, has been of great and material assistance to the army; aiding the Medical Department in every way, either when short of supplies or in want of means of transport, and it is now so well organized, that at a moment's notice it can send to the front, or to any other place, from the base of field operations, any quantity of necessaries. The Commission is continually receiving from all the large cities in the Union, as well as from private sources, supplies, either in money or materials, which are constantly arriving at the base of field operations, and are obtainable for hospital use on requisition made by brigade and divisional surgeons. The internal organization of this Commission is remarkably well arranged, and reflects the highest credit on those connected with it."

*Pennsylvania State Medical Board.*—A Medical Board, convened by order of Surgeon General Phillips, of this State, will assemble in Philadelphia on the 6th of March, to examine candidates for appointment as Assistant-Surgeons in Pennsylvania Regiments. Physicians in good health, furnishing proper testimonials as to moral character, &c., will be admitted to the examination.

*Jewish Hospital Association.*—A society under this title was organized at Philadelphia on the 19th of February. The following gentlemen were elected officers:—

*President.*—Alfred T. Jones.

*Vice President.*—J. Binswanger.

*Treasurer.*—S. Weil.

*Secretary.*—Mayer Sulzberger.

*Directors.*—Joseph Einstein, Abraham S. Wolf, M. M. Bayerdorfer, Judah Isaacs, M. D., E. W. Arnold, R. Brunswick, Rev. Isaac Leeser, M. Thatheimer, Wm. B. Hackenburg, Jacob May, Simon Ezekiel, S. Alexander.

Liberal donations were subscribed at the meeting, and a committee appointed to obtain members. Special provision is made in the laws of this Society to admit patients of other denominations, should they apply.

*Vital Statistics of Philadelphia, 1864.*—It appears from the annual report recently made to the Board of Health that the whole

number of *births* registered during the year 1864 was 15,591, being an increase over the previous year of 298 or 1.94 per cent. Of these the number of coloured children was 242, a decrease of 50 from the previous year.

The number of *marriages* registered was 6752, an increase of 1278 or 23.36 per cent. over the previous year.

The number of *interments* was 17,582, an excess of 1791 or 11.29 per cent. over the previous year. Of these 1,309 were of coloured persons, being an excess of 542, or nearly 71 per cent. over that of the previous year.

*Toland Medical College.*—This is the title of a new institution recently chartered at San Francisco, California. The college building, which is said to be large and convenient, was erected by Dr. H. H. Toland, and with the lot on which it stands was most liberally presented by him to the trustees of the Institution.

The faculty consist of the following gentlemen:—

H. H. TOLAND, M. D., President and Professor of the Principles and Practice of Surgery.

JAMES BLAKE, M. D., Professor of Obstetrics and Diseases of women and children.

J. NEWTON BROWN, M. D., Professor of Anatomy.

C. L. LANE, M. D., Professor Institutes of Medicine.

WM. O. AYRES, Professor Theory and Practice of Medicine.

J. F. MORSE, M. D., Professor of Clinical Medicine and Diagnosis.

THOMAS BENNETT, M. D., Professor of General Pathology.

H. GIBBONS, M. D., Professor of Materia Medica.

ROBERT OXLAND, M. D., Professor of Chemistry.

#### FOREIGN INTELLIGENCE.

*Lesion produced by Lifting Children by the Wrist.*—Dr. BOUREAUX comments upon an unnamed lesion which is produced by the sudden raising of children, of from 18 months to 3 years old by the wrists. Some place its seat in the wrist, others in the shoulder, and the majority in the elbow. Great pain immediately follows the acci-

dent, the child's arm hanging down by the side, with the forearm in a state of marked pronation. When the arm is left to itself, supported in a sling, the pain subsides gradually, and in the course of two or three days the normal movements are recovered. When a surgeon is consulted—and the author has met with more than 150 of these cases—he is not able to detect any displacement, deformity, or tumefaction; but when the child's cries have become somewhat pacified, he finds that it is the movement of the forearm on the arm which gives rise to most of the pain. M. Bourgeois, from a consideration of the anatomy of the parts and the mode in which the force is applied, comes to the conclusion that the lesion consists in a slight displacement of the head of the radius in the direction of its axis; in other words, in a diastasis of the superior radio-cubital articulation, similar to that often observed at the lower end under other circumstances. Seating the child on the lap of an assistant, he grasps the elbow with the palm of the left hand, so as to keep the limb firm by surrounding it with the fingers, and then, taking hold of the lower part of the forearm with the right hand he rotates it outwards, and flexes it at a right angle. A slight cracking is rather felt than heard, and the power of moving the arm is restored at once.—*Ibid.*, from *L' Union Méd.*

*Baron Liebig's Soup for Children.*—With that remarkable estimation of the greatness of small things which is one of the most valuable of his many high intellectual qualities, and with a tender appreciation of the importance of small people Baron Liebig devotes a special article in an English scientific periodical<sup>1</sup> to the description of a new article of diet which he conceives to be the most fitting substitute for the natural nutriment for those children who are by circumstances robbed of their mother's milk. It is well known that cow's milk does not adequately represent the milk of a healthy woman, and when wheaten flour is added, as it commonly is, Liebig points out that, although starch be not unsiting for the nourishment of the infant, the change of it into sugar in the stomach during digestion imposes an unnecessary labour on the organization which

will be spared it if the starch be beforehand transformed into the soluble forms of sugar and dextrine. This he effects by adding to the wheaten flour a certain quantity of malt. As wheaten flour and malt flour contain less alkali than woman's milk, he supplies this when preparing the soup. This "soup" may be shortly prepared as follows: "Half an ounce of wheaten flour, and an equal quantity of malt flour, seven grains and a quarter of bicarbonate of potash, and one ounce of water, are to be well mixed; five ounces of cow's milk are then to be added, and the whole put on a gentle fire; when the mixture begins to thicken it is removed from the fire, stirred during five minutes, heated and stirred again till it becomes quite fluid, and finally made to boil. After the separation of the bran by a sieve, it is ready for use. By boiling it for a few minutes it loses all taste of the flour."

The immediate inducement for his making the soup was that one of his grandchildren could not be suckled by its mother, and that another required, besides his mother's milk, a more concentrated food. In both cases, as well as in other families where it had been introduced, the soup proved an excellent food, the children thrived perfectly well, and many a petty suffering disappeared after some weeks' use of the soup. He often takes it prepared with ten parts of milk and two parts of malt flour, with tea, for his breakfast. He adds that "Dr. Von Pfeuffer, the most renowned physician in Munich, has induced the apothecaries of the town to keep for sale a mixture of half an ounce of malt flour and seven grains and a quarter of bicarbonate of potash, milk and wheat flour being supposed to be in every house. The malt flour ought to be always freshly made from the malt."—*Lancet*, Jan. 7, 1865.

*Re-vaccination in Belgium.*—M. VLEMINCX, the President of the Belgian Academy of Medicine, has made an interesting communication to that body upon the subject of re-vaccination. In a paper read in 1862 he gave an account of 2018 re-vaccinations, and now adds 823 additional observations, making in all 2841, the subjects being inmates of prisons and penitentiaries. In 1518 of these subjects exhibiting distinct vaccination marks, re-vaccination succeeded in 308, or 19 per cent., and in 599, who had

<sup>1</sup> The Popular Science Review. Edited by Henry Lawson, M. D. No. XIV., January, 1865. R. Hardwicke, Piccadilly.

distinct cicatrices from variola, it succeeded in 178, or 30 per cent. An analysis of the ages of these subjects leads M. Vleminckx to the following conclusions: 1. Re-vaccination is successful in proportion to the length of time that has elapsed since the first vaccination or an attack of variola. 2. It may be generally dispensed with prior to the twenty-fifth year. 3. From that age its protective power progressively increases. 4. The fact of its proving unsuccessful on the first occasion should not prevent our having recourse to it at a future period, as we have no proof that the receptivity may not have returned in the interval. 5. The re-vaccination of children at schools is useless, for not one of the 2841 cases manifested a return of receptivity prior to the 15th year. Do these principles equally apply to the subjects of smallpox? To answer this question we must first be able to determine whether the manifestation of receptivity of vaccine virus by them positively indicates a condition of the economy which does not render them exempt from a second attack of variola. This is probable, but not demonstrated. However this may be, such persons should not hesitate to submit themselves to re-vaccination, which, while it is itself a harmless procedure, may save from a second attack of variola. M. Vleminckx adds that every precaution has been taken to secure the greatest exactitude in these figures, all cases having been rejected which seemed to admit of a shadow of doubt. The subjects of re-vaccination had always been duly vaccinated, or had had undoubted variola; and where signs of this were not distinct, the re-vaccinations were not counted, although successful.—*Med. Times and Gaz.*, Nov. 26, 1864.

*Anesthesia by Chemically Pure Ether.*—MM. Regnault and Advan, pharmacists, laid before the Imperial Academy of Medicine, Dec. 27, 1864, a work on the method of obtaining chemically pure sulphuric acid. M. GOSSELIN stated that at the request of MM R. and A. he had tried their pure sulphuric ether, and found its effects far more rapid and certain than that of ordinary ether, and that the period of excitement did not occur. Four to eight minutes sufficed for the production of complete anesthesia, and as death had been produced in a certain number of cases from the inhalation of chloroform, whilst none had resulted from

ether, he thought the latter should be preferred to the former.—*Révue de Thérapeutique Méd.-Chir.*, Jan. 15, 1865.

*Anesthesia from Chloroform, prolonged by Subcutaneous Injections of Morphia.*—Experiments have lately been made upon dogs, by a committee appointed by the Medical Society of Versailles, to test the value of the above method. Five experiments were undertaken. On the first dog chloroform inhalation alone caused anesthesia for nineteen minutes; with inhalation and the injection of about half a grain of morphia, thirty-six minutes. On a second dog, with chloroform inhalation alone, the anesthesia lasted thirty minutes; but the same inhalation followed by an injection of one grain of morphia caused an anesthetic state of one hour and twenty-seven minutes. The same experiment being repeated, with an injection of one grain and one-tenth of morphia, produced anesthesia for five hours and forty-four minutes. The committee state in their report that the prolongation of anesthesia by subcutaneous injections of morphia must be admitted as a fact, although they do not wish to be over-positive, seeing that their experiments are but few, and, in one instance, performed twice upon the same animal.—*Lancet*, Jan. 14, 1865.

*Hospital Hygiene.*—The correspondent of the *British Medical Journal*, in giving an account of the recent meeting of the Association of German Naturalists and Physicians at Giessen, states: "I went to the clinique of Professor Roser, now one of the most eminent teachers and practitioners of surgery in Germany. This is a beautiful new building of red sandstone, for the reception of surgical cases only. The great feature of it is, that there are no wards containing more than four beds, and most of them contain only two. Professor Roser said that if he could help it, he would never collect more than two surgical cases in one room. Accordingly, he has a minimum of pyæmia, and great success in surgical operations. There is, at last, a practical condemnation of those dens of wound-poison, the enormous wards of general hospitals. When, at Leipzig, I saw the crowded wards, the spasmodic anxiety to effect ventilation by all manner of openings, and the shed in the yard of

the hospital, where, in beds, all badly suppurating cases are kept, as if in the open air—all the horrors of pyæmia as I had seen it in military hospitals, and, in a lesser degree, in civil hospitals, abroad and in this country, came before me. I remember a conversation which I had with Professor Bardeleben, of Greifswald, on the repeated use of bandages. This surgeon causes all bandages and dressings which have been once applied to open wounds to be immediately destroyed. Cheap calico serves all his purposes, and assists in preventing pyæmia. I had advocated long ago that bandages should not be used twice in the dressing of wounds or open sores, because I knew that they could not be cleaned, or, in fact, were never cleaned effectually. I came to Leipsic; and in the hospital uttered this opinion to Dr. Neumann. Almost offended, he called for the nurse in charge of the bandages. No. 1, unexceptionable; No. 2, unexceptionable. No. 3, full of yellow and otherwise coloured stains. They were packed up in silence. "We cannot get them out, sir," said the nurse. "Exactly so," said I; "that is just what I said to Dr. Neumann. You ought not, in my opinion, to be charged with the filthy and disgusting service of washing used bandages; it infects your fingers and clothes; it saves pence, and costs lives. The washed bandage is the carrier of infection, which keeps open the old and callous sore upon the leg. But the new wound—woe to him who has it! If your forceps, your lint, your charpie, impregnated with the hospital air, your infected bandage, touch it, it is death." If nurses in lying-in hospitals are obliged to wash infected clothes of any kind, or if such are used, no one need be astonished at the outbreaks of fever amongst lying-in women. They are as certain consequences of this sort of bad management as pyæmia is of the "clean" bandages and "pure" air of general hospitals. But in Professor Roser's place, there was nothing of the kind to be objected to. True, the walls were not done in "Parian" and "non-absorbing;" but the wounds looked healthy. A boy, with the eighty-fourth tracheotomy of Professor Roser upon him, was recovering so fast that, on the second day after removal of the canula, he could cough strongly, and show that the hole in his windpipe was permanently closed. From the clinique, we went in a

body to the anatomy building. There dislocations of the elbow backwards were made and set. But the greatest lesson was the treatment of wounds of the skull with depression. With a little chisel and hammer, small fragments at the margin of the fracture were removed, and then the fragments of the inner table could be removed with the forceps with ease, and the wound cleared of every obstruction. There was a new demonstration how unnecessary and irrational that operation is which passes under the name of trephining. I have denounced it for fourteen years, with a large and successful experience in the treatment of compound fractures of the skull, particularly from gunshot wounds, by my side. If I live a little longer, I shall see Desault's idea, for he conceived it first, and Stromeyer's teaching, for he gave it a living breath, victorious.—*British Med. Journ.*, Nov. 26, 1864.

*Mortality at the Maternité Hospital, Paris.*—During a recent discussion at the Paris Hospital Society, M. Guyot stated that having replaced M. Hervieux at the hospital Maternité during three months, he found that the mortality exceeded all that he could have imagined; of 492 women who entered for delivery between July 15 and October 1, 91 died; and of 174 who entered the infirmary as patients 82 died. During the first fortnight of October, 15 other deaths had to be added to this frightful list, and even this did not represent the entire number of women who had contracted the germs of death in this establishment, for a certain number left it in a desperate state to die either at other Hospitals or at home. It was from purulent infection rather than metrorrhagia that these unfortunate women succumbed. In M. Guyot's opinion the establishment ought to be suppressed, especially as the conditions of the lying-in wards of the various Paris Hospitals are in a far more satisfactory state. The mortality observed at the Maternité was not the result of an epidemic, but the ordinary state of affairs there. M. Gallard observed that the Paris Maternité did not stand alone in this matter, for at the Vienna Maternité and in all establishments in which agglomerations of lying-in women exist puerperal fever is endemic.—*Med. Times and Gas.*, Dec. 17th, 1864.

*Two-fold Inoculation; or, the True Chancre complicated with the Soft Venereal Ulcer.*—As a very considerable amount of scepticism and misconception appears to prevail on this subject, and as it is in accordance with our own observation, we must dwell a little upon this knotty point, which is, in reality, a very simple one. Let us assume, as an hypothesis, that there are two distinct poisons, producing, the one a local, the other a constitutional affection, and that these are not interchangeable. Now, as the latter alone possesses a true incubation, it follows that if a man be exposed to the two poisons at once, the soft local sore will first appear, and will run its course during the incubation of the other, and that we may thus have a soft sore, which becomes hard before it heals, from the action and development of the true syphilitic element. Instances of this are not very uncommon; and the converse may equally happen, whenever a patient labouring under an indurated chancre exposes himself to the virus of the local soft sore. If the poisons produce their results in close proximity one with another, we can then watch these separately and mark the contrasts in their characters; but if one and the same abrasion be inoculated with both poisons, from exposure to one or many sources of contagion within a limited period of time, then, we have the two diseases existing together, or one succeeding the other, on the same spot. So that if we see the common, soft form of sore, we can positively pronounce it to be, so far, a local disease; frankly telling our patient at the time, however, what is the interval before any syphilitic poison would declare itself and the characters by which it may be known. If there be no such appearances afterwards we can most surely guarantee the local nature of the disease.

So long, however, as we had to depend upon our observation of cases contracting the diseases in the ordinary way, we might never, perhaps, have demonstrated the fact of this double inoculation; but this has now been effected by artificial inoculation. Under ordinary circumstances, these occurrences were, of course, strongly suggestive of a variety only in the processes and the unity of their cause, and so long was Nature apparently giving the contradiction to all our distinctions between the infecting and non-infecting forms of sores. Now,

however, a specific induration has been inoculated with the pus of the soft ulcer, a pustule has formed, and the characteristic soft sore has resulted. We will give a few examples of the two modes by which the occurrence has been traced. Take that related by M. Fournier (which was seen by M. Ricord) of a double inoculation in the natural way. A man was labouring under a chancre affected with cartilaginous induration. This suddenly began to ulcerate, and, coincidently therewith a large soft sore appeared on the skin of the penis. One of the indurated chain of inguinal glands inflamed and suppurated, and the pus from it was successfully inoculated. "Secondaries" subsequently appeared. Now, it was proved that this patient had contracted these soft ulcers from sexual intercourse with a woman suffering from the same affection, at the time he was under treatment for his indurated chancre. M. Rollet and his interne, M. Laroyenne, have succeeded many times in producing the pustule and soft ulcer by the artificial inoculation of an indurated sore with the pus of soft sores. Instances of similar experiments may be met with in most of the recent works of Continental Syphiliographers. Although the poisons and their manifestations are mixed, in so far as they both appear in the same locality, one does not destroy nor essentially modify the other: both follow their ordinary courses and preserve their characters. Nor is the subsequent manifestation of secondaries arrested or modified apparently by the induced ulceration of the chancre or the presence of suppuration in the groin. It is asserted even further, that it is possible to take pus from the artificially-produced pustule on the induration, or that of the bubo in the groin, and to produce a soft sore by inoculation on the same, or on another healthy individual; that is, provided the secretion used be pure and unmixed with any blood.—*Med. Times and Gaz.*, Jan. 28, 1865.

*Communication of Syphilis through Catheterism of Eustachian Tube.*—What we should here regard as almost impossible appears to be of not unfrequent occurrence in France; viz., the communication of syphilis through catheterism of the Eustachian canal. Several cases of the kind have already been related; one or two of them authen-

# DICTIONARY MEDICAL

GOING TO MEDICAL SKILL AND PRACTICE

## FOREIGN INTELLIGENCE.

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ticated by M. Ricord. M. Lailier now records another carefully observed case, and gives full details of it; from which it would seem certain that the patient was affected with syphilis; that the disease arose subsequent to the frequent catheterism of the Eustachian tube for deafness; and that the catheterism was the cause of the infection. It really, as we have said, seems incomprehensible, that any aurist could be guilty of such a filthy and shameful act as using dirty instruments in cases of this kind; but we must record what seems thoroughly well authenticated facts.—*Brit. Med. Journ.*, Oct. 15, 1864.

*Conjuring and Animal Magnetism.*—An anecdote is told in the *Union Méd.* which illustrates the correct reply when we are called upon to explain some of the feats of alleged animal magnetizers—viz., that these are equalled and even surpassed by those of avowed conjurors. At a recent soirée in Paris a celebrated *prétenditateur* was amusing the company with his wonderful skill, when M. Tardieu, the Dean of the Faculty of Medicine, was announced. The conjuror was introduced to M. Tardieu just as he was excusing himself for being so late. “That is nowise surprising,” was the reply, “for Monsieur has either been robbed of or lost his watch.” M. Tardieu put his hand to his waistcoat, and sure enough there was his chain without the watch. This was in the conjuror’s hand! How he could have detached it from the chain without M. Tardieu or the bystanders perceiving it quite passes explanation.—*Med. Times and Gaz.*, Jan. 28, 1865.

*Extraordinary Ordinance of Louis XIV. requiring Physicians to withhold their Services to Patients seriously ill, who refuse to be confessed.*—In his recent report upon the position and relations of the Medical Profession, made by M. André Latour to the French Medical Association, while advertizing to the project of demanding additional Medical legislation at the hands of the ruling powers, he noticed incidentally a remarkable ordonnance promulgated by Louis XIV. towards the end of his reign, in which he menaced with deprivation any physician who, called to a patient suffering from a dangerous disease, neglected to apprise him of his danger, and to see that he was duly confessed by a priest.

The *ordonnance* as to confession was issued at the instigation of Cardinal Noailles, Archbishop of Paris, and bears date Ver-  
sailles, March 8, 1712. The following are extracts:—

“We hereby declare and ordain as our royal will and pleasure that all Physicians of our kingdom shall hold themselves bound upon the second day of their visiting patients attacked by fevers or other diseases which by their nature may lead to death, to exhort them to confess, or to cause their family to give them this advice. And in the case that neither the patients nor their friends seem disposed to follow this advice, the Physicians shall hold themselves obliged to advertise the curate or vicar of the parish in which such patients dwell, and obtain a certificate from them to the effect that such advertisement has been given. Physicians are prohibited visiting these patients on the third day, unless the confessor has duly certified to them that such patients have confessed, or at all events that the confessor has seen them and prepared them for the reception of the sacramento. Physicians who have thus apprised the confessors of the residences of such patients, and are provided with certificates from them of their having done so, are at liberty to continue their attendance without incurring the subjoined penalties. We will that those Physicians who may contravene this our present declaration shall be condemned for the first offence to a fine of 300 *livres*; that for the second they shall be interdicted from all functions or practice during at least three months; and that for the third offence they shall be deprived of their degrees, their names erased from the lists of the faculties, and prohibited for ever from practising in any part of our kingdom.”

In addition, it is stated that when the urgency of the case demands it, the patients must be urged to confess even before the second day. In the absence of physicians, surgeons and apothecaries are enjoined to perform this duty under similar penalties.—*Med. Times and Gaz.*, Dec. 31st, 1864.

*French Regard for Poland.*—The Minister of Public Instruction has just made known to the rectors of the different faculties of the kingdom that by the Emperor’s wish Polish students should be admitted to all Lectures without fees.

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